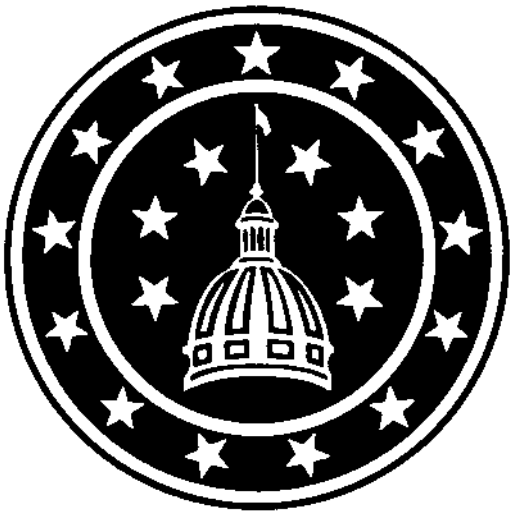
ANNUAL REPORT
OF THE
SELECT JOINT COMMISSION ON
MEDICAID OVERSIGHT



Indiana Legislative Services Agency
200 W. Washington Street, Suite 301
Indianapolis, Indiana 46204

November, 2008

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2008

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SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

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A copy of this report is available on the Internet. Reports, minutes, and notices are organized by committee. This report and other documents for this Committee can be accessed from the General Assembly Homepage at http://www.in.gov/legislative/.

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly enacted legislation (IC 2-5-26) directing the Commission to do the following:

> (1) Determine whether the contractor for the office under IC 12-15-30 that has responsibility for processing provider claims for payment under the Medicaid program has properly performed the terms of the contractor's contract with the state.
> (2) Determine whether a managed care organization that has contracted with the office to provide Medicaid services has properly performed the terms of the managed care organization's contract with the state.
> (3) Study and propose legislative and administrative procedures that could help reduce the amount of time needed to process Medicaid claims and eliminate reimbursement backlogs, delays, and errors.
> (4) Oversee the implementation of a case mix reimbursement system developed by the office and designed for Indiana Medicaid certified nursing facilities.
> (5) Study and investigate any other matter related to Medicaid.
> (6) Study and investigate all matters related to the implementation of the children's health insurance program established by IC 12-17.6.

In addition, the Commission was charged by the Legislative Council (LCR 08-01) to determine whether a managed care organization that has contracted with the Office of Medicaid Policy and Planning to provide Medicaid services has properly performed the terms of the managed care organization's contract with the state (SEA 42-2008).

II. SUMMARY OF WORK PROGRAM

The Commission met four times during the 2008 interim session: July 21, 2008, in Kokomo, Indiana; August 20, 2008, September 16, 2008, and October 22, 2008, at the State House in Indianapolis.

At the July 30th meeting in Kokomo, Commission members heard testimony from multiple Medicaid and food stamp recipients and advocates who were having difficulties with the privatization of eligibility determination for the food stamps program, TANF program, and Medicaid program.

The August 20th meeting discussed the following subjects concerning the Medicaid program: mental health services, dental services, presumptive eligibility for pregnant women, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The expansion of eligibility for participation in the Children's Health Insurance Program (CHIP) program was also discussed.

At the September 16th meeting, the Commission heard testimony on the disproportionate share hospital payment system, TANF program changes, an update on the eligibility determination privatization, pharmacy carve out for managed care in the Medicaid program, and nursing home reimbursement.

At the October 22nd meeting, the Commission heard testimony on: (1) incontinence supplier issues within the Medicaid program; (2) FSSA proposed rules on long term care changes to comply with the federal Deficit Reduction Act of 2005; (3) the nursing home Closure and Conversion Fund; and (4) an update on medical informatics. The Commission also considered proposed bill drafts, the final report, and Commission findings.

IV. SUMMARY OF TESTIMONY

ACS/IBM Privatization and Modernization

The Commission heard testimony on the county roll out of FSSA's eligibility determination privatization and modernization plan at the July 31st meeting and the September 16th meeting. FSSA Secretary Mitch Roob testified that it is difficult to determine whether the privatization has affected enrollment in Food Stamps, TANF, and Medicaid because of the flooding in Indiana, the emergency participation in these programs, and the difficulty for flooding victims to participate in the process. According to Secretary Roob, modernization has given FSSA substantial flexibility that helped with FSSA's response to the flood. FSSA was able to mobilize services to the flood counties to help those affected. In response to the flood, FSSA extended Medicaid eligibility for flood recipients who were previously eligible for Medicaid. CMS has retroactively approved this action, and FSSA is now seeking federal reimbursement for the costs of this action. Secretary Roob testified that the flooding in the state from Hurricane Ike has postponed further county rollouts until at least December. The next region to be rolled out is the Lake and Porter County area. FSSA staff is currently busy assisting those people affected by the flood and in need of assistance, including disaster food stamps.

Commission members commented that they have received complaints from constituents who have called the call centers and are often waiting 45 minutes to one hour, and that this is hard on people who are working and need to take time off for these calls, as well as being difficult on disabled individuals. Program participants and various advocates also testified before the Commission on the numerous problems they were facing with new system. Individuals testified that documents are frequently lost, employees answering the help line are not fully educated on the various programs, and individuals are being terminated from the program without notice and for processing mistakes or lost documents. Commission members expressed concern to FSSA regarding the modernization plan.

Secretary Roob also testified concerning the use of Volunteer Community Assistance Networks (V-CAN) to assist individuals in navigating the new enrollment system for Medicaid, TANF, and

food stamps. Secretary Roob stated that there are 1,260 organizations participating as V-CANs. When asked whether Indiana considered compensating these organizations like Florida does, Secretary Roob stated that they did not take Florida's approach because, unlike Florida, FSSA wanted to keep at least one county office open in each county. When asked whether this places a burden on V-CANS when they do not receive any compensation, Secretary Roob stated that medical providers participating as V-CANs do receive a stream of cash flow, so he is not concerned with this group. As far as other groups of V-CAN participants, such as food banks and township trustees, that is a different matter and he is not opposed to compensation for them but is just trying to work within his budget.

A couple of V-CAN participants described the problems they have incurred, including the cost of participating as a V-CAN, and said that face to face interviews in determining eligibility for programs have been almost completely cut out although some individuals really need this interaction to participate in the process. Other issues that were discussed included: individuals are placed on hold and documents are lost; the online information is inconsistent with information provided by a live person; the application is now much longer; and there is confusion as to whether those people who have been told they have lost their coverage under the program should reapply or appeal.

Ms. Kitty Thode, representing Waters of Indiana nursing homes, testified that the new Medicaid application is too long, and that redetermination calls are made without notice. Ms. Thode recommended that nursing homes be given a separate contact person to call with problems.

Dental Services in Medicaid

Mr. Ed Popcheff, representing the Indiana Dental Association, stated that the Association has some concerns with dental services offered in the Medicaid program. First, despite a minor reimbursement rate increase earlier this year, Medicaid reimbursement in comparison to private insurance is underfunded. Second, dental services under Medicaid for adults are capped at $600. This amount may be sufficient for routine exams and maintenance, but often Medicaid adults first present with significant dental problems that exceed the capped amount. Third, Medicaid spenddown is problematic because the dental provider does not know if the individual has met the individual's required spenddown amount before the services can be provided and the dental care provider is often required to submit the reimbursement at the end of the month after the individual has met the monthly spenddown. This issue is particularly prevalent in the rural areas of the state and is resulting in dentists ceasing to participate in the Medicaid program. In response to a question from the Chairperson regarding emphasizing preventative dental care because of the dental issues that can affect the overall health of an individual, Mr. Popcheff stated that the Indiana Dental Association is supporting a "Born to Smile" program that focuses on establishing a dental home for a mother and newborn before the child is one year old.

Secretary Mitch Roob stated that there is a need for providers in different specialties to work together to provide services to pregnant women, and that dental concerns are a health issue for

pregnant women. Concerning the reimbursement rates, Secretary Roob stated that Medicaid's dental rates have been deemed by outside sources to be actuarially sound.

Mental Health Services in Medicaid

Mr. Matt Brooks, representing the community mental health centers, stated that the centers have three issues regarding the carve in of behavioral mental health services by managed care organizations under the Medicaid program. First, the administrative costs of providing all of the documentation required by the managed care organizations are high. Second, the time frame in which payment is received for services provided by the community mental health centers is too long. The third issue is the financial viability of the subcontractors providing behavioral health services for the managed care organizations. Mr. Brooks requested free and consistent training for community mental health center staff in the administrative and documentation requirements of the subcontractors. Mr. Brooks stated that there has been better uniformity for services covered by the subcontractors in the last couple of months.

Ms. Pat McGuffey, representing the Indiana Psychological Association, stated that psychologists have decreased their acceptance of Medicaid patients since privatization. Psychologists have listed the following reasons for reducing services to Medicaid patients: (1) the pre-authorization procedures are very laborious while reimbursement is very low; (2) payments are very late, often as late as six months after the claim is submitted, and denials happen too frequently, requiring appeals; (3) the credentialing process is unduly burdensome; and (4) licensed practitioners are having difficulty getting reimbursement for Master level practitioners and students under the licensed practitioner's supervision.

Secretary Roob testified that the reimbursement time frames for mental health services by managed care organizations range from an average of six to seventeen days.

CHIP Eligibility Percentage

Legislation passed in 2007 authorized an increase in the income eligibility percentage in the Children's Health Insurance Program (CHIP) from 200% of the federal poverty level to 300% of the federal poverty level (FPL). FSSA has received approval from the federal government to increase CHIP eligibility to 250% of the federal poverty level, effective October 1, 2008. Commission members asked whether FSSA is going to seek approval to increase CHIP eligibility to the statutorily authorized 300%. Secretary Roob stated that the federal government first indicated that it would not approve a state's request to increase CHIP eligibility above 250% of FPL. However, there have been recent indications that the federal government may be changing this position, and Secretary Roob stated that he would inquire about this possibility with the federal government.

Presumptive Eligibility for Pregnant Women under Medicaid

Chairperson Crawford asked Secretary Roob whether FSSA would be seeking federal approval as required by state statute to provide presumptive eligibility for pregnant women under Medicaid. Secretary Roob stated that FSSA will be doing so after several legislators had pointed out to him how to more broadly define an enrollment center in order to better implement the federal requirements for presumptive eligibility.

EPSDT Screening

Chairperson Crawford asked Secretary Roob about how well Indiana meets the federal requirement of providing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for its Medicaid children population when managed care organizations receive a bonus from FSSA for providing EPSDT to 35% to 40% of the required population. Secretary Roob responded that tracking this information is difficult because FSSA only has access to claims data, not to a patient's medical record, and the best data available is the Health Effectiveness Data and Information Set (HEDIS) measures reported by the managed care organizations to FSSA. However, FSSA does not usually receive the HEDIS information from the managed care organizations until sixteen months later and the data is usually too old to be useful. FSSA stated that the incentives paid to managed care organizations for meeting EPSDT goals set by FSSA total $5 million. When asked whether a managed care organization has been sanctioned for not providing EPSDT testing in the past, Secretary Roob stated that he could not recall a sanction for this reason.

Disproportionate Share Hospital (DSH) Payment System

Intergovernmental transfers (IGTs) historically have been used through distribution transfers by the Marion County Health and Hospital Corporation, Clarian/Indiana University, municipal entities, state mental health hospitals, and other state appropriations. The federal government is currently considering changing the types of entities that may perform IGTs and if Clarian is not allowed by the federal government to do this in the future, it would result in a $100 million ($300 with federally leveraged dollars) loss in Medicaid funding. Secretary Roob stated that the results of the presidential election may affect how the federal government proceeds with this issue and that the federal government may not resolve the issue until after the Indiana General Assembly adjourns in 2009, causing issues with addressing the issue in the next session. Secretary Roob stated that possible actions concerning DSH include: (1) creating new streams of IGTs; (2) providing supplemental funding to Riley Children's Hospital; (3) creating new coverage programs for uninsured Indiana residents, including subsidizing individuals to participate in employer health plans or in the private market; (4) increasing payments to hospitals for Medicaid recipients; or (5) changing disability coverage from federal 209(b) status to 1634 status (deeming that an individual who is eligible for federal SSI is also eligible for Medicaid).

Secretary Roob discussed the changes to DSH as a result of HEA 1001-2008, in which funding of HCI was moved from local property taxes to sales taxes. Marion County was provided $40 million for 2009 since Marion County did not have a HCI tax. This distribution was only agreed

on for 2009, and the issue will probably have to be addressed in the budget this year for the subsequent years. Before the changes made in 2008, Lake County hospitals provided the majority of the IGT, and usually received 100% of the hospitals' capitated amount in return, even though some individual hospitals did not receive the hospitals' full capitated amount. Now, FSSA will have the same amount of generated IGTs, but the source of the dollars has changed, and the distribution among the hospitals in relation to the hospitals' capitated amounts will probably change as well.

TANF Changes Update

Many programs are funded in Indiana through Indiana's federal TANF block grant. Indiana's TANF caseloads have decreased recently at the lowest rate in the nation -- six percent. The new federal regulations require states to have higher work participation rates, and if the state does not meet these rates, the state will lose a portion of the state's TANF block grant and will be required to replace those lost dollars with state dollars in order to receive the remaining block grant funds. Indiana's numbers in work participation have been improving as a result of implementing a new system. Only one vendor is now used, and TANF recipients are placed into training the day they enroll in the program. Secretary Roob stated that Indiana is on the path to meeting the federal 50% work participation percentage required to not lose its funding. Indiana has a one year grace period and must meet this 50% requirement by 2009 or lose a portion of the funding in 2010.

Managed Care and the Medicaid program

The Commission was charged by the Legislative Council to determine whether each managed care organization (MCO) that has contracted with the Office of Medicaid Policy and Planning to provide Medicaid services has properly performed the terms of the managed care organization's contract with the state. The Commission submitted questions to each MCO concerning its participation in the Medicaid program. Chairperson Crawford stated that Stephanie DeKemper, John Cardwell, and Melanie Hobbs voluntarily reviewed the MCO responses and made determinations concerning whether the MCOs were performing specific terms of the state contract and provided the Commission with their findings. The findings are included as exhibits in the October 22, 2008 meeting minutes.

The Commission also discussed a proposal FSSA is studying concerning carving out pharmacy services for the Hoosier Healthwise population (pregnant women and children). The pharmacy benefit for this population is currently included in the monthly cap provided to the MCO for the recipient. In determining whether to change this, Secretary Roob stated that FSSA has asked various interested parties whether a change would detrimentally affect the patient. So far, no one has argued that a change would inhibit quality of care. Secretary Roob testified that the goal is to standardize the formulary and step away from the current system in which there are four pharmacy formularies for this population, depending on whether the recipient participates in the Medicaid fee for service program or uses one of the three MCOs. FSSA is studying the monetary ramifications of such a change. Secretary Roob stated that there has been no decision yet as to

whether to make this change.

Nursing home admissions and acute levels of care

Secretary Roob stated that FSSA has identified about 1200 individuals currently in nursing homes that, based on the individual's Resource Utilization Grouping (RUG) scores, may be able to live outside of a nursing home setting. FSSA is considering changing nursing home reimbursement so that it is based on RUG scores. Secretary Roob stated that the goal is to use nursing home rates to encourage the direction of home and community based care. FSSA recently began discussions with the nursing home associations and the Area Agencies on Aging about this concept. A representative of a nursing home stated concerns with shifting the nursing home reimbursement in this manner and the effect on a patient if the infrastructure to provide home and community based care is not available and the nursing homes are offered a reimbursement that creates a disincentive to accept these patients. Chairperson Crawford stated that he is concerned about the infrastructure being in place and referred to the past decision to de-institutionalize mental health care when outside mental health services were not available.

Incontinence services under the Medicaid program

Ms. Judy Bunn, representing the Association of Indiana Home Medical Equipment Services (AIHMES), stated that FSSA reported that 6,465 Medicaid recipients are receiving incontinence supplies, but the contract had estimated 11,000 Medicaid recipients would be using the services. Ms. Bunn questioned the cause of the low enrollment. Ms. Bunn also stated that FSSA has received complaints from only 36 members, but members have not been given a telephone number or other means to make these complaints. AIHMES has received twice that number of complaints. The complaints include the long waiting period before a person receives the supplies requested, as well as the amount of supplies received -- either too much or not enough. Ms. Bunn questioned FSSA's response that the 36 complaints FSSA had received had been satisfactorily resolved and asked whether the complainant would agree with this assessment. Ms. Bunn asked whether FSSA is achieving the savings it projected in limiting the number of supply vendors being used for the Medicaid program.

Dr. Jeff Wells, Director of Medicaid, FSSA, stated that the only Medicaid recipients affected by the incontinence supplier changes are the Care Select population of about 70,000 participants. Dr. Wells informed the Commission that FSSA has been looking into the complaints and has spoken with AIHMES. Dr. Wells stated that FSSA cannot take action if it does not know about the complaints. The incontinence supply contract contains a cap on the maximum quantity of a supply that FSSA will pay for an individual in a month. Dr. Wells further informed the Commission that the savings FSSA projected from the incontinence supply contract were included in FSSA's projected savings submitted to the federal government for the Healthy Indiana Plan 1115 demonstration waiver that was approved. FSSA will survey Medicaid recipients after six months of the program and annually thereafter.

Chairperson Crawford stated that the Commission was not going to take any official action at this time, but that the issue could be addressed during the legislative session with a bill if necessary.

Long term care changes as a result of the federal Deficit Reduction Act of 2005

Mr. Keith Huffman, President of the Indiana Chapter of the National Academy of Elder Law Attorneys, stated that FSSA's proposed DRA compliance rules are harsh and would hurt many Indiana residents seeking Medicaid assistance. Six proposals of concern address: (1) transfers of property -- gifts; (2) the return of gifts; (3) the timing period for penalties; (4) annuities; (5) personal services agreements; and (6) undue hardship exceptions.

First, the DRA requires Indiana to adopt new Medicaid rules concerning transfers of property. FSSA's proposed rule states that all gifts, no matter how small, made within the last five years before applying for Medicaid, can be added together to create a penalty period that begins running only when a person has entered a nursing home and the person is eligible for Medicaid. Mr. Huffman recommended looking at other states who ignore certain small dollar figure gifts.

Mr. Huffman also discussed how to treat returned gifts. FSSA's proposed rule requires the individual to return the entire amount that was given within the five-year look back period before the penalty period will be shortened. The DRA does not require this, and Mr. Huffman suggested that Indiana should give full credit for the partial return of gifts.

Mr. Huffman informed the Commission that federal law now requires a purchaser of an annuity to name Indiana as the primary or contingent beneficiary or be subject to a penalty period of time in which the person is ineligible for Medicaid. FSSA's proposed rule about annuities is retroactive and applies to a non-qualified annuity that was purchased on or after February 8, 2006. This proposal penalizes individuals who purchased annuities without a warning about the change in federal law. Mr. Huffman recommended that this proposed rule apply prospectively and that customers be given notice about the beneficiary naming requirement.

Mr. Huffman further informed the Commission that FSSA's proposed rule addresses personal services agreements even though this subject was not addressed in the DRA. FSSA's proposed rule requires a prior written personal services agreement, even if the services are provided by a family member, and does not allow a personal services agreement to be entered into by a power of attorney or guardian.

Mr. Huffman testified that the DRA recognized that state implementation of this law would be difficult and required states to have undue hardship exceptions to allow states not to penalize for certain conduct. FSSA's proposed rules only allow for an individual to request an undue hardship within 20 days and require the individual to prove that the individual has used every legal means to obtain return of the asset. Because an individual cannot request the return of a gift to a charity, the individual would be ineligible for the undue hardship exception. Mr. Huffman recommended rewriting the proposed rules.

Secretary Roob assured the Commission that his staff is meeting with the elder law groups and reviewing the public comments it has received concerning the proposed rules. Secretary Roob stated that any proposed rules would not be promulgated until 2009 and several changes will be made. In response to a question from a Commission member, Secretary Roob stated that the federal Centers for Medicare and Medicaid Services (CMS) have never questioned the state's timeliness in implementing the DRA provisions.

Closure and Conversion Fund

Secretary Roob made the following responses to the Commission's questions concerning the nursing home closure and conversion fund established as part of the negotiations with the nursing homes on the nursing home quality assessment fee:

1. What was the balance of the Closure and Conversion Fund at the end of Fiscal Year 2008: $37.4 million

2. How much money from the fund was used and for what purpose? $9.1 million for nursing home rate increases

3. What is the balance of the fund for Fiscal Year 2009? $28.3 million

4. How much is projected to be used from the fund in 2009? $22.3 million for moving from 5% to 7% increase in reimbursement

5. How much is left in the fund at end of Fiscal Year 2009: $6 million

6. What is the account number of the fund? It does not have a separate account number.

Secretary Roob stated that the initial purpose of the fund to purchase Medicaid nursing home beds to remove them from the system was denied by CMS. Instead, FSSA and the nursing homes agreed that the money would be used for nursing home rate increases. Mr. Vince McGowen, representing HOPE, agreed generally with Secretary Roob's comments about the closure and conversion fund, adding that the closure and conversion fund was never statutorily defined.

Medical Informatics Update

Senator Dillon spoke about his involvement in this issue and said that he hopes that medical information technology would help improve patient care and save money. Chairperson Crawford commended Senator Dillon and FSSA for their work in this area. Dr. Jeff Wells, FSSA, gave a Powerpoint presentation on Indiana's work on implementing medical informatics in Indiana and stated that Indiana is one of the most advanced states in using electronic health records.

V. COMMITTEE RECOMMENDATIONS

The Commission considered the following preliminary drafts and took the following action:

PD 3214, Taxes on alcoholic beverages to fund health care, T. Brown. This PD increases the excise taxes on all alcoholic beverages, with the increased revenue to be deposited in a newly established health care fund as follows: (1) 25% to increase Medicaid reimbursement for physician providers in Medicaid; and (2) the remaining 75% for the disproportionate share hospital program, the health care for the indigent program, and the upper payment limit program. The Commission voted 7-6 to recommend the bill proposal.

PD 3391, Quality assessment fee extension, Crawford. This PD originally extended the nursing home quality assessment fee for one year. Rep. T. Brown moved that the assessment be extended until 2013, and the motion carried on a vote of 10-1. The Commission voted 10-1 to recommend the bill proposal, as amended.

PD 3404, Case manager assignment in eligibility determinations, Simpson. This PD requires the Division of Family Resources (DFR) to assign a state employee to each Medicaid, TANF, and food stamp application and to inform the applicant of the assigned employee's name and phone number. It also specifies that the state employee is responsible for the case until an eligibility determination is made. The Commission voted 9-2 to recommend this bill proposal.

PD 3403, Use of contractor for eligibility determinations, Crouch. This PD prohibits FSSA from using a contractor to make eligibility determinations in Medicaid, TANF, and food stamps in additional counties after November 1, 2008, until the Commission has reviewed the changes and status of the counties that have used the contractor before November 1, 2008. The Commission voted 7-4 to recommend this bill proposal.

PD 3393, Disproportionate share hospital (DSH) payments program study, Crawford. This PD requires the Office of Medicaid Policy and Planning to develop, maintain, and use a computer system to store specified DSH documents. It also establishes an interim study committee on Medicaid supplemental programs in 2009 to study specified issues and requires the Legislative Evaluation and Oversight Policy Subcommittee to study the DSH program in 2009. The Commission voted 11-0 to recommend this bill proposal.

PD 3395, Restoration of county offices of family resources, Errington. This PD eliminates the authority for DFR to replace county offices with regional offices and requires DFR to reorganize and restore any county offices that have been consolidated. The Commission voted 6-5, and the bill proposal was not recommended by the Commission. (Seven affirmative votes are required for the Commission to take action on a matter.)

PD 3392, Medicaid contract time frames, Simpson. This PD specifies that a four year limitation on Medicaid contracts includes contracts concerning eligibility determination and

application processing for benefits. The Commission voted 6-5 and the bill proposal was not recommended by the Commission.

PD 3398, Requirements for FSSA contractors, Crawford. This PD requires a DFR or county office employee to directly assist an individual who goes to the county office seeking assistance in completing applications for programs serviced by the county office. It also sets forth requirements that FSSA must apply to a eligibility determination contractor and requires FSSA to pay voluntary community assistance networks $10,000 for assisting FSSA. The Commission voted 6-5 and the proposed bill was not recommended by the Commission.

Approval of Final Report and Findings

Upon proper motion and second, the final report of the Commission, with the inclusion of the testimony and actions of the October 22nd meeting, was approved by a vote of 11-0.

Chairperson Crawford informed the Commission that he has put together findings concerning the various topics discussed by the Commission over the interim. A Commission member questioned the language of one of the findings dealing with the CHIP program, and Chairperson Crawford stated that the CHIP finding would be removed.

The following findings were approved by the Commission:

Timely Response and Production of Requested Documents by FSSA to the Commission

Receiving information and associated documentation on a timely basis for decision making from FSSA in the pursuit of their legislatively authorized duties is essential to the efficiency and effectiveness of the Commission as they embark on the deliberative process of meaningful programmatic oversight.

In those instances where the transmittal of information has not occurred, or has been significantly delayed, adverse or imprudent policy consequences for the Indiana Medicaid Program can potentially materialize. Additionally, the lack of transparency and the absence of the full involvement of the stakeholders in the FSSA decision making process militates against the basic tenets of "good government

The Commission finds that the Family and Social Services Administration should strive in all instances to be as forthcoming and transparent as possible when it comes to providing the Commission with the information and documentation that it requests and needs to reach reasoned decisions and conclusions.

Eligibility/Modernization System Impact on Entitled Individuals Seeking Assistance

In the transition to the new Eligibility/Modernization application system, the Commission finds

that on numerous instances applicants utilizing the new application system are experiencing a myriad of barriers to successfully completing the Medicaid application and redetermination process.

The following impediments include, but are not limited to: The loss or misplacement of properly tendered documents by the Eligibility/Modernization vendor, lack of material assistance by staff in helping individuals who appear in person for assistance at a local Division of Family Resources Office where they go seeking assistance in filling out and submitting their application package, and lack of unitary staff contact continuity for those individuals having to contact the State more than once as they attempt to navigate and successfully complete the application process.

The Commission finds that more applicant-friendly structural improvements need to be undertaken in the application intake process.

Voluntary Community Assistance Networks (V-Can) Contribution

The V-Can network has provided and continues to provide substantive assistance to the State of Indiana in the Eligibility/Modernization process and acknowledgment of the V-Can contribution is affirmatively noted by the Commission.

Medicaid Supplemental Payment System (Disproportionate Share Hospital et al)

Medicaid Supplement Programs (including the Disproportionate Share Hospital program) total approximately $1 billion dollars in funding to the Indiana Medicaid program on annual basis.

The Commission finds that the Disproportionate Share Hospital (DSH) program faces material funding jeopardy as a consequence of actions at the federal level involving recently proposed Intergovernmental Transfer (IGT) statutory developments.

Managed Care Organizations (MCO) are an Essential Component of the Medicaid Program

MCOs are an essential component of Indiana's Medicaid Program. A clear and concise understanding among all interested parties of how the MCO process works and should work is vital to the effective functioning of this essential health care delivery system for the Indiana Medicaid Program.

The Commission finds the following:

(1) FSSA (OMPP) is required to notify the Commission of program or contract changes that would:

-Substantially affect contracts with third-party vendors, including MCO's or other suppliers to the program, and any items that require advance notice to

the MCO's or contractors under the contract terms;

-Substantially affect Medicaid program members or providers' members;

-Require notification or reporting to CMS;

-Implement a system that allows for real time reporting and timely determination for members' spend down balances.

(2) FSSA should develop a uniform data collection system that can be used by all MCOs to share member information as needed to address members who move from one MCO to another.

W I T N E S S L I S T

Ms. Wendy Adcock, self
Mr. Matt Brooks, Community Mental Health Centers
Ms. Judy Bunn, AIHMES
Mr. Glenn Cardwell, advocate
Mr. John Cardwell, Generations project
Ms. Laverna Davis, self
Senator Gary Dillon
Representative Ron Herrell
Mr. Keith Huffman, attorney
Ms. Patsy Janecek, self
Ms. Lola Jordan, EDS
Mr. Vince McGowen, HOPE
Ms. Pat McGuffey, Indiana Psychological Association
Ms. Linda Munro, self
Mr. Ed Popcheff, Indiana Dental Association
Ms. Cathy Purvis, self
Mr. Peter Rivera, self
Secretary Mitch Roob, FSSA
Mr. Gavin Rose, attorney
Mr. Dan Skinner, self
Ms. Kitty Thode, Waters of Indiana nursing homes
Ms. Jessaca Turner-Stults, FSSA
Ms. Kay Walker, Center Township Trustee of Delaware County
Dr. Jeff Wells, FSSA
Ms. Myra Wilkey, Mental Health America of Vigo County
Mr. Steve Woodall, self
Ms. Jennifer Workman, self